MANAGED CARE CHECKLIST:
REQUIREMENTS FOR PROVIDER CONTRACTS

NOTE TO COMPANIES COMPLETING THIS CHECKLIST: ***Please include a completed checklist for each provider contract when submitting an application for or a material change to an insured preferred provider plan pursuant to M.G.L. c. 176I or an application for or a material change to accreditation pursuant to M.G.L. c. 176O indicating, as applicable, the page number(s), and/or section(s), where the required information may be found in the submitted materials. Please indicate if a requirement is not applicable (N/A) and explain the reason(s) why.***

Carrier Name: _____

NAIC #: _____

Contact Name & Title: _____

Address: _____

Telephone: _____

Fax: _____

Email Address: _____

Date Received: _____

Reviewed by: _____

Contract Name & Form #: _____

_____

Required language in provider contracts

_____ According to 211 CMR 52.12(1)(a) and (b), "[c]ontracts between carriers and health care providers shall state that a carrier shall not refuse to contract with or compensate for covered services an otherwise eligible health care provider solely because such provider has in good faith:

(a) communicated with or advocated on behalf of one or more of his prospective, current or former patients regarding the provisions, terms or requirements of the carrier's health benefit plans as they relate to the needs of such provider's patients; or
(b) communicated with one or more of his prospective, current or former patients with respect to the method by which such provider is compensated by the carrier for services provided to the patient."

_____ According to 211 CMR 52.12(2), "[c]ontracts between carriers and health care providers shall state that the provider is not required to indemnify the carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the carrier based on the carrier's management decisions, utilization review provisions or other policies, guidelines or actions."

_____ According to 211 CMR 52.12(3)(a)-(c), "[n]o contract between a carrier and a licensed health care provider group may contain any incentive plan that includes a specific payment made to a health care professional as an inducement to reduce, delay or limit specific, medically necessary services covered by the health care contract.

(a) Health care professionals shall not profit from provisions of covered services that are not medically necessary or medically appropriate.

(b) Carriers shall not profit from denial or withholding of covered services that are medically necessary or medically appropriate.

(c) Nothing in 211 CMR 52.12(3) shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of insureds if such contracts, which impose risk on such physicians or physical groups for the costs of medical care, services and equipment provided or authorized by another physician or health car provider, comply with 211 CMR 52.12(4)."

Please confirm that the carrier complies with this requirement and reference the section(s) of the provider contracts that address this requirement.

_____ According to 211 CMR 52.12(4)(a)-(c), "[n]o carrier may enter into a new contract, revise the risk arrangements in an existing contract, or after July 1, 2001, revise the fee schedule in an existing contract with a physician or physician group which imposes financial risk on such physician or physician group for the costs of medical care, services or equipment provided or authorized by another physician or health care provider unless such contract includes specific provisions with respect to the following:

(a) stop loss protection,

(b) minimum patient population size for the physician or physician group, and

(c) identification of the health care services for which the physician or physician group is at risk."

Please provide a statement that advises whether the carrier has issued new contracts as described above, and if so, reference the section(s) of the provider contract that address 211 CMR 52.12(4)(a)-(c).

_____ According to 211 CMR 52.12(5), "[c]ontracts between carriers and health care providers shall state that neither the carrier nor the provider has the right to terminate the contract without cause."

_____ According to 211 CMR 52.12(6), "[c]ontracts between carriers and health care providers shall state that a carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment."

_____ According to 211 CMR 52.12(7), "[c]ontracts between carriers and health care providers shall state that the carrier shall notify providers in writing of modifications in payments, modifications in covered services or modifications in a carrier's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the carrier and the provider."

_____ According to 211 CMR 52.12(8), "[c]ontracts between carriers and health care providers shall state that providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance."

_____ According to 211 CMR 52.12(9), "[c]ontracts between carriers and health care providers shall prohibit health care providers from billing patients for nonpayment by the carrier of amounts owed under the contract due to the insolvency of the carrier. Contracts shall further state that this requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination."

_____ According to 211 CMR 52.12(10), "[c]ontracts between carriers and health care providers shall require providers to comply with the carrier's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services."

_____ According to M.G.L. c. 176I, § 2 (or M.G.L. c. 176G, § 6), contracts must contain a provision requiring that within 45 days after the receipt by the carrier of completed forms for reimbursement, the carrier shall (1) make payment, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete the forms for reimbursement. If the carrier fails to comply with these requirements for any claims related to the provision of health care services, the carrier shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the carrier's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions relating to interest payments shall not apply to a claim that the carrier is investigating because of suspected fraud. (See also M.G.L. c. 175, § 110(G); M.G.L. c. 176A, § 8(e); M.G.L. c. 176B, § 7; and Bulletin 00-13)

_____ Early in 2002, the Division became aware that certain providers in the Massachusetts market intended to modify their practices in April 2002 by charging an annual fee to members as a condition to continue to be part of the providers' panel of patients. The Division was formally requested by certain carriers to opine as to whether carriers would be permitted to continue to include providers within their managed care networks if those providers required such fees as a condition for treatment. As is noted in a letter dated March 6, 2002 to Tufts Health Plan, the Division's General Counsel indicated that it does not believe that the providers' annual fee proposal "violates the current statutory and regulatory framework governing contracts between carriers and providers." The Division's General Counsel's letter of March 6, 2002 instructs all carriers to "incorporate provisions into their contracts with providers, provider groups or networks that require advance disclosure or notification by the provider to the carrier of any such arrangements [to charge an annual fee to members as a condition to continue to be a part of a providers' panel of patients]."

Definitions as outlined in M.G.L. c. 176O, § 1 and 211 CMR 52.03 (if used within contract)

_____ Emergency medical condition, "a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B)."

_____ Medical necessity or medically necessary, "health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:
(a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
(b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
(c) for services and interventions not in widespread use, is based on scientific evidence."

_____ Participating provider, "a provider who, under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier."

_____ Utilization review, "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review."

Requirements that may either be in provider contracts or otherwise distributed to providers

_____ According to M.G.L. c. 175, § 47U(b) (or M.G.L. c. 176G, § 5(b), c. 176A, §8U(b) and c. 176B, § 4U(b)), carriers shall provide coverage for emergency services provided to insureds for emergency medical conditions. After an insured has been stabilized for discharge or transfer a carrier may require a hospital emergency department to contact a physician on-call designated by the carrier or its designee for authorization of post-stabilization services. The hospital emergency department shall take all reasonable steps to initiate contact with the carrier or its designee within 30 minutes of stabilization. However, such authorization shall be deemed granted if the carrier or its designee has not responded to the call within 30 minutes. In the event the attending physician and the on-call physician do not agree on what constitutes appropriate medical treatment, the opinion of the attending physician shall prevail and such treatment shall be considered appropriate treatment for an emergency medical condition provided that such treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the policy or contract.

_____ According to M.G.L. c. 175, § 47U(c) (or M.G.L. c. 176G, § 5(c), c. 176A, § 8U(c) or c. 176B, § 4U(c)), a carrier may require an insured to contact either the carrier or its designee or the primary care physician of the insured within 48 hours of receiving emergency services, but notification already given to the carrier, designee or primary care physician by the attending physician shall satisfy this requirement.

_____ According to M.G.L. c. 176O, § 10(c), "[a] carrier or utilization review organization shall conduct an annual survey of insureds to assess satisfaction with access to specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services . . . [and c]arriers that utilize incentive plans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of health care services of insureds."

_____ According to M.G.L. c. 176O, § 12(b), "[a] carrier or utilization review organization shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information . . . [and I]n the case of a determination to approve an admission, procedure or service, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the insured and the provider within two working days thereafter. In the case of an adverse determination, the carrier or utilization review organization shall notify the provider rendering the service by telephone within 24 hours, and shall provide written or electronic confirmation of the telephone notification to the insured and the provider within one working day thereafter."

_____ According to M.G.L. c. 176O, § 12(c), "[a] carrier or utilization review organization shall make a concurrent review determination within one working day of obtaining all necessary information. In the case of a determination to approve an extended stay or additional services, the carrier or utilization review organization shall notify by telephone the provider rendering the service within one working day, and shall provide written or electronic confirmation to the insured and the provider within one working day thereafter. A written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services. In the case of an adverse determination, the carrier or utilization review organization shall notify by telephone the provider rendering the service within 24 hours, and shall provide written or electronic notification to the insured and the provider within one working day thereafter. The service shall be continued without liability to the insured until the insured has been notified of the determination."

_____ According to M.G.L. c. 176O, § 12(d), "[t]he written notification of an adverse determination shall include a substantive clinical justification therefor that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum: (1) identify the specific information upon which the adverse determination was based; (2) discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; (3) specify any alternative treatment option offered by the carrier, if any; and (4) reference and include applicable clinical practice guidelines and review criteria."

_____ According to M.G.L. c. 176O, § 12(e),"[a] carrier or utilization review organization shall give a provider treating an insured an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. Said reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the provider rendering the service and clinical peer reviewer or a clinical peer designated by the clinical peer reviewer if said reviewer cannot be available within one working day. If the adverse determination is not reversed by the reconsideration process, the insured, or the provider on behalf of the insured, may pursue the grievance process established pursuant to [M.G.L. c. 176O, §§] 13 and 14. The reconsideration process allowed herein shall not be a prerequisite to the formal internal grievance process or an expedited appeal required by [M.G.L. c. 176O, §] 13."

_____ According to M.G.L. 176O, § 16(a) "[t]he physician treating an insured, shall, consistent with generally accepted principles of professional medical practice and in consultation with the insured, make all clinical decisions regarding medical treatment to be provided to the insured, including the provision of durable medical equipment and hospital lengths of stay. Nothing in this section shall be construed as altering, affecting or modifying either the obligations of any third party or the terms and conditions of any agreement or contract between either the treating physician or the insured and any third party."

_____ According to M.G.L. 176O, § 16(b) "[a] carrier shall be required to pay for health care services ordered by a treating physician if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined herein. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians in the carrier's or utilization review organization's service area; (ii) developed in accordance with the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (iv) evidence based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured."

_____ According to M.G.L. 176O, § 16(c) "[w]ith respect to an insured enrolled in a health benefit plan under which the carrier or utilization review organization only provides administrative services, the obligations of a carrier or utilization review organization created by this section and related to payment shall be limited to recommending to the third party payor that coverage should be authorized."

_____ According to 105 CMR 128.501, "[c]arriers shall allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with said pregnancy is involuntarily disenrolled for reasons other than those related to quality or fraud, to continue treatment with said provider, consistent with the carrier's evidence of coverage, for a period up to and including the insured's first postpartum visit."

_____ According to 105 CMR 128.502, "[c]arriers shall allow any insured who is terminally ill, and whose provider in connection with the treatment of the insured's terminal illness is involuntarily disenrolled for reasons other than those related to quality or fraud, to continue treatment with said provider, consistent with the terms of the carrier's evidence of coverage, until the insured's death."

_____ According to 105 CMR 128.503(A), "[a] carrier shall provide coverage for health services to a newly insured provided by a physician who is not a participating provider in the carrier's network for up to thirty days form the effective date of coverage if: (1) the insured's employer only offers the insured a choice of carriers in which said physician is not a participating provider; and (2) said physician is providing the insured with an ongoing course of treatment or is the insured's primary care physician."

_____ According to 105 CMR 128.503(B), "[w]ith respect to an insured pregnant woman who is in her second or third trimester, coverage pursuant to 105 CMR 128.503(A) shall apply to services rendered through the insured's first postpartum visit."

_____ According to 105 CMR 128.503(C), "[w]ith respect to an insured with terminal illness, coverage pursuant to 105 CMR 128.503(A) shall apply to services rendered until the insured's death."

_____ According to 105 CMR 128.504(A), "[a] carrier may condition coverage of continued treatment by a provider under 105 CMR 128.500 through 128.502, upon the provider's agreeing: (1) to accept reimbursement from the carrier at the rates applicable prior to the notice of disenrollment as payment in full; (2) to not impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; (3) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and, (4) to adhere to such carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any, approved by the carrier."

_____ According to 105 CMR 128.504(B), "[a] carrier may condition coverage of treatment by a provider under 105 CMR 128.503 upon the provider's agreeing: (1) to accept reimbursement from the carrier at the rates applicable to participating providers as payment in full; (2) to not impose cost sharing with respect to the insured in an amount that would exceed the cost sharing that could have been imposed if the provider participated in the carrier's network; (3) to adhere to the quality assurance standards of the carrier and to provide the carrier with necessary medical information related to the care provided; and (4) to adhere to the carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any, approved by the carrier."

_____ According to 105 CMR 128.505(A), "[a] carrier that requires an insured to designate a primary care physician shall allow such a primary care physician to authorize a standing referral for specialty health care, including mental health care, provided by a health care provider participating in such carrier's network when: (1) the primary care physician determines that such referrals are appropriate; (2) the provider of specialty health care agrees to a treatment plan for the insured and provides the primary care physician with all necessary clinical and administrative information on a regular basis; and (3) the health care services to be provided are consistent with the terms of the carrier's evidence of coverage." It is further noted in 105 CMR 128.505(B) that "[n]othing in 105 CMR 128.505 shall be construed to permit a provider of specialty health care who is the subject of a referral to authorize any further referral of an insured to any other provider without the approval of the insured's carrier."

_____ According to 105 CMR 128.506(A), "[n]o carrier that requires an insured to obtain referrals or prior authorizations from a primary care physician for specialty care shall require an insured to obtain a referral or prior authorization from a primary care physician for the following specialty care provided by an obstetrician, gynecologist, certified nurse-midwife or family practitioner participating in such carrier's health care provider network: (1) annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse-midwife or family practitioner to be medically necessary as a result of such examination; (2) maternity care; and (3) medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions." In addition, according to 105 CMR 128.506(B), "[n]o carrier shall require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care physician." It is further stated in 105 CMR 128.506(C), "[c]arriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse-midwives or family practitioners to communicate with an insured's primary care physician regarding the insured's condition, treatment, and need for follow-up care."

_____ According to M.G.L. c. 176O § 2(d), "[a] carrier that contracts with another entity to perform some or all of the functions governed by this chapter shall be responsible for ensuring compliance by said entity with the provisions of this chapter. Any failure by said entity to meet the requirements of this chapter shall be the responsibility of the carrier to remedy and shall subject the carrier to any and all enforcement actions, including financial penalties, authorized under this chapter." **Please confirm that the carrier is aware of this requirement and that the carrier has submitted, as applicable, all contracts between (1) the carrier and any delegated entity and (2) the delegated entity and providers.**